BARKLY STREET DENTAL GROUP

Title: Surname:		Given Names:
Date of Birth:		Occupation:
Phone Home		Address:
Phone work		
Phone Mobile		
Email Address:		

Private Health Fund Name:	Membership Number:	Reference Number: **(Next to your name eg: 01)**

Emergency Contact: Name and Number	
To complete if patient is under 18 years old	
Guardian name and contact address and phone details	

Name your GP		Phone	
GP Address:			

Referral Information:

Walked past	Internet
Specialist	GP
Patient:	

Have you ever had any of the following? Please tick those that apply:

Anaemia	Fainting	Pacemaker
Artificial Joints	Glaucoma	Radiation Therapy
Asthma	Heart Disease	Respiratory Problems
Blood Disease	Heart Murmur	Rheumatic fever
Cancer	Hepatitis A, B, C	Sinus problems
Dizziness	Jaundice	Stroke
Epilepsy	Kidney Disease	Tuberculosis
Excessive Bleeding	Liver Disease	Tumours
Diabetes	HIV / AIDS	Psychological disorders
Are you pregnant? If so how many months?		

PLEASE CONTINUE TO NEXT PAGE

Any serious illnesses or accidents in the past 2 years?	
Medications:	
Allergies:	
Blood Pressure Normal, High or Low?	
Do you smoke? Per day?	

DENTAL HISTORY

Reason for your visit today (tick as many boxes that apply)

- Examination and/or Hygiene
- Broken tooth/lost restoration
- Tooth Ache
- Sensitivity to hot or cold
- Food trap between teeth
- Clicking/pain in jaw joint
- Tooth clean techniques (e.g. brushing / flossing)
- Your smile
- Discolouration of teeth
- Silver fillings
- Previous dental treatment
- Crooked teeth
- Missing teeth
- Other

How long since your last visit? : ______________________________

Does dental treatment make you nervous?

No	Slightly	Moderately	Extremely

- I have completed this history to the best of my knowledge and understand that failure to do so could put me in undue medial risk. I understand that my notes/radiographs or models relating to my treatment may have to be sent to other practitioners to aid them in my treatment and I consent to this. I give Barkly Street Dental Group permission to contact me via mail, phone or email and I also understand that it is my responsibility to update my personal details.
- I, the undersigned, consent to the performing of dental surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures.
- I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee of $100.00 could be incurred if I fail to do so. Also that if I repeatedly cancel an appointment I will be asked to pre-pay in order for treatment to be fulfilled.
- I am aware that full payment is required on the day of service.

____ ________________________

Patient signature **Date**